

NOV 15 1937

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36371  
Do not use this space.

791

1008

1. PLACE OF DEATH

(a) County..... Registration District No. /  
(b) Township..... Primary Registration District No. /  
(c) City St. Louis (d) Street No. City Hospital No. 1 St. (If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

C. 9594 Baby Kiger

2. PRINT FULL NAME 1043 Allen

(a) Residence, No. .... St. 23 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
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8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis, Missouri  
(STATE OR COUNTRY)

FATHER 13. NAME Fred Kiger  
14. BIRTHPLACE (CITY OR TOWN) Illinois  
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME G oldie Blake  
16. BIRTHPLACE (CITY OR TOWN) Annapolis, Missouri  
(STATE OR COUNTRY)

17. INFORMANT Hosp. Info M. Kent  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE City Sematary DATE 10/29/37

19. FUNERAL DIRECTOR Devil Van Fossen  
(ADDRESS) C. H. #1

20. FILED OCT 27 1937 J. E. Brebeck  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/2/37, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/1/37, 19, to 10/2/37, 19.

I last saw him live on 10/2/37, 19. Death is said to have occurred on the date stated above, at 12.50 a.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia

Other contributory causes of importance:

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify Pneumonia  
(Signed) P. Anderson, M. D.

(Address) City Hospital No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**